STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155596	A. BUILDING _____ B. WING _____	C 02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND SKILLED NURSING AND REHABILITATION	500 N WILLIAMS ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00085379. Complaint IN00085379 - Substantiated, Federal/State deficiencies related to the allegations are cited at F272, F280, and F323. Survey dates: February 3, 4, 2011 Facility number: 000474 Provider number: 155596 AIM number: 100290510 Survey team: Ann Armey, RN Census bed type: SNF: 5 SNF/NF: 62 Total: 67 Census payor type: Medicare: 5 Medicaid: 39 Other: 23 Total: 67 Sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2. Quality review completed 2/9/11 by Jennie Bartelt, RN.	F 000	This Plan of Correction is the center's credible allegation of compliance. Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficienceis. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. RECEIVED FEB 24 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		

app 3/3/11 BM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judith L Sweet — TITLE: Administrator — (X6) DATE: 2-23-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident at risk of falls was thoroughly assessed before a device used to alert staff to the resident's rising unassisted was discontinued. This deficient practice affected 1 of 3 residents who were at risk of falls in a sample of 3. (Resident #B)	F 272	It is the policy of this facility to initially and periodically conduct a comprehensive, accurate, a standardized, reproducible assessment of each resident's functional capacity. Resident B was re-evaluated upon readmission to this facility on 1-19-11. A fall risk assessment was completed with a score indicating high risk. The care plan was reviewed and updated on 1-19-11 to include new interventions of low bed with mat at bedside on floor. New orders were also received from the doctor for a chair pressure alarm, a mobility alarm and a raised edge mattress. All were place in use on 1-19-11. On 1-27-11 and 1-28-11 all resident charts were reviewed for appropriate and timely fall risk assessments. Those residents that triggered as high risk received an additional audit for appropriate interventions and care plans. On 1-27-11 and 1-28-11, nursing staff consisting of RN, LPN and QMA's	* 2-4-11 5

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F 272	Continued From page 2 Findings include: On 2/3/11 at 9:00 a.m., during the orientation tour, the ADON (Assistant Director of Nursing) indicated Resident #B had fallen in the facility and had sustained a hip and wrist fracture. The ADON indicated Resident #B was hospitalized after the fall and returned to the facility following a surgical repair of the hip fracture but currently was in the hospital because a screw in the hip had become displaced. The clinical record of Resident #B was reviewed on 2/3/11 at 10:00 a.m. and indicated the resident was admitted to the facility on 12/3/10 for rehabilitation following a hospitalization for an appendectomy with peritonitis. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, and osteoporosis. The resident had been residing in an assisted living facility prior to her appendicitis. The fall risk assessment, dated 12/3/10, indicated the resident was at high risk of falls and had "intermittent confusion." Admission physician orders, dated 12/3/10, indicated, "Mobility alarm on @ (at) all times (check mark) q (every) shift." Therapy notes indicated Occupational Therapy was started on 12/6/10, Physical Therapy on 12/7/10, and Speech Therapy on 12/13/10. Nursing notes, dated 12/8/10, indicated, "D/c (discontinue) mobility alarm res (resident) uses call light appropriately to convey needs...." There was no documentation Resident #B safety needs were comprehensively assessed or that the	F 272	were re-educated on completing fall risk assessments and forwarding recommendations to the IDT prior to discontinuing any safety measure or device. They were also re-educated that the care plan must be updated and reflect any changes for any new or discontinued intervention. A Fall committee was formed that reviews any fall for root cause, any change in risk level and to add any new interventions. All residents are reviewed with IDT walking rounds the next business day after any fall. Director of Nursing and/or Designee will monitor during routine rounds to ensure that continued compliance is obtained. This area will be reviewed 5x week for one month, per 24 hour report sheets, telephone orders and fall reports, then weekly x4, then monthly through random audits and IDT rounds. Results of the audits will be reported monthly to the QA Committee for review. The QA Committee responsible, to the Administrator, will review audits for continued compliance.	

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F 272	Continued From page 3 Physical or Occupational Therapists were consulted before the mobility alarm was discontinued. During interview on 2/3/11 at 1:30 p.m., LPN #10, who had discontinued the mobility alarm for Resident #B, indicated she felt the resident's confusion had cleared, the resident was using her call light, was continent, and the family wanted her to be more independent. LPN #10 indicated she did not discuss discontinuing the mobility alarm with the therapists. The fall risk care plan, dated 12/10/10, indicated the resident was at risk of falls related to psychotropic medication, diuretic medication, osteoporosis, Parkinson's, poor safety awareness, dementia and weakness. A Social Services 30 day summary, dated 12/27/10, indicated the resident received a score of 7 on the BIMS (Brief Interview for Mental Status) indicating the resident had severe mental status impairment (0-7 severe impairment). Physical Therapy Summary notes, between 1/11/11 and 1/14/11, indicated the resident required contact guard assist for safe transfer and ambulation due to unsteadiness. The summary indicated the resident was a fall risk and "safety precautions include need for verbal, tactile and visual cues." The note further indicated "Pt (patient) is attempting to walk without assistive devices or assistance from caregivers...." Occupational Therapy Summary notes between 1/8/11 and 1/14/11 indicated, "Patient impulsive and frequently gets up from wheelchair to walk behind it with no assistance."	F 272		

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F 272	Continued From page 4 Speech Therapy Summary between 1/8/11 through 1/14/11, indicated the resident was able to demonstrate ability to follow safety precautions with moderate ability (51 to 70% of the time) and had mild cognitive impairment. On 1/14/11 at 5:30 p.m., nursing notes indicated the resident was found on the floor in the doorway of her room. The resident complained of pain in her right hip and right wrist. Subsequently, the resident was sent to the hospital and admitted with a fractured right wrist and right hip. On 2/3/11 at 11:30 p.m., the Director of Rehabilitation was interviewed about Resident #B's mobility alarm. The Director of Rehabilitation indicated Resident #B was getting stronger and her balance was improving but she still needed assistance to transfer and had no safety awareness. The Director indicated she did not recall having any input when the alarm was discontinued and she felt Resident #B should have had a mobility alarm. On 2/4/11 at 11:00 a.m., the DON (Director of Nursing) indicated the IDT (Interdisciplinary Team), including a therapist, discussed Resident #B and identified no new safety issues on 12/30/10 but they had not met formally after 12/30/10 and no new interventions were initiated. The DON further indicated staff were inserviced on 1/27/11 and 1/28/11 and fall risk assessments were to be done before the discontinuation of mobility alarms or fall preventative measures. Finally, the DON indicated, after the fall, the IDT met to evaluate the effectiveness of the fall prevention interventions for all residents at risk for falls.	F 272		

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F 272	Continued From page 5 The Fall Management Procedure, dated 10/10, provided by the DON, was reviewed on 2/4/11 at 11:30 a.m., and indicated, "...3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries...." This federal tag relates to Complaint IN00085379. 3.1-31(a)	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 280	It is the policy of this facility to develope a comprehensive care plan based on the comprehensive assessment of the resident with input from the IDT, physician, resident and family. Updates to the care plan are completed by a team of qualified persons after each assessment and review of the care plan. Resident B was re-evaluated upon readmission to this facility on 1-19 -11. A fall risk assessment was completed with a score indicating high risk. The care plan was reviewed and updated on 1-19-11 to include new interventions of low bed with mat at bedside on floor. New orders were also received from the doctor for a chair pressure alarm, a mobility alarm and a raised edge mattress. All were placed in use on	* 2-4-11 5

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F 280	Continued From page 6 failed to assure the fall risk care plan was updated when the resident began to attempt to get up unassisted. The resident was not supervised, fell and fractured her hip and wrist. This deficient practice affected 1 of 3 residents who were at risk of falls in a sample of 3. (Resident #B) Findings include: On 2/3/11 at 9:00 a.m., during the orientation tour, the ADON (Assistant Director of Nursing) indicated Resident #B had fallen in the facility and had sustained a hip and wrist fracture. The ADON indicated Resident #B was hospitalized after the fall and returned to the facility following a surgical repair of the hip fracture but currently was in the hospital because a screw in the hip had become displaced. The clinical record of Resident #B was reviewed on 2/3/11 at 10:00 a.m. and indicated the resident was admitted to the facility on 12/3/10 for rehabilitation following a hospitalization for an appendectomy with peritonitis. The resident's diagnoses included but were not limited to, Parkinson's disease, dementia, and osteoporosis. The resident had been residing in an assisted living facility prior to her appendicitis. The fall risk assessment, dated 12/3/10, indicated the resident was at high risk of falls and had "intermittent confusion." Admission physician orders, dated 12/3/10, indicated, "Mobility alarm on @ (at) all times (check mark) q (every) shift." Therapy notes indicated Occupational Therapy	F 280	1-19-11 and the care plan was updated to include all interventions. On 1-27-11 and 1-28-11 all resident charts were reviewed for appropriate and timely fall risk assessments. Those residents that triggered as high risk received an additional audit for appropriate interventions and care plans. On 1-27-11 and 1-28-11, nursing staff consisting of RN, LPN and QMA's were re-educated on completing fall risk assessments and forwarding recommendations to the IDT prior to discontinuing any safety measure or device They were also re-educated that the care plan must be updated and reflect any changes for any new or discontinued intervention. A Fall committee was formed that reviews any fall for root cause, any change in risk level and to add any new interventions. All residents are reviewed with IDT walking rounds the next business day after any fall. Director of Nursing and/or Designee will monitor during routine rounds to	

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F 280	Continued From page 7 was started on 12/6/10, Physical Therapy on 12/7/10, and Speech Therapy on 12/13/10. Nursing notes, dated 12/8/10, indicated, "D/c (discontinue) mobility alarm res (resident) uses call light appropriately to convey needs...." There was no documentation Resident #B safety needs were comprehensively assessed or that the physical or occupational therapists were consulted before the mobility alarm was discontinued. The fall risk care plan, dated 12/10/10, indicated the resident was at risk of falls related to psychotropic medication, diuretic medication, osteoporosis, Parkinson's, poor safety awareness, dementia and weakness. The care plan included the following interventions: provide adequate lighting, monitor side effects of medication, keep call light within reach, encourage use of call light, keep floors free of spills and clutter, monitor unsteady gait and balance. instruct to avoid sudden position changes, labs as ordered, assess toileting needs, provide verbal safety cues, keep personal belongings within reach, keep assistive devices within easy reach: (walker, wheelchair), wear clear and clean eye wear, provide non-skid foot wear, Physical Therapy evaluation and treatment, and Occupational Therapy evaluation and treatment. No additional interventions were implemented until 1/19/11, after the resident returned from the hospital, following the repair of her hip fracture.	F 280	ensure that continued compliance is obtained. This area will be reviewed 5x week for one month, per 24 hour report sheet, telephone orders, and fall reports, then weekly x4, then monthly through random audits and IDT rounds. Results of the audits will be reported monthly to the QA Committee for review. The QA Committee responsible to the Administrator will review audits for continued compliance.	

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F 280	Continued From page 8 Nursing notes indicated the following: On 1/4/11 at 8:30 p.m., Resident #B was showing increased independence and was walking without help in her room and down the hall. On 1/11/10 at 8:35 p.m., resident was found to be walking in the hall without her wheel chair. Physical Therapy Summary notes, between 1/11/11 and 1/14/11, indicated the resident required contact guard assist for safe transfer and ambulation due to unsteadiness. The summary indicated the resident was a fall risk and "safety precautions include need for verbal, tactile and visual cues." The note further indicated, "Pt (patient) is attempting to walk without assistive devices or assistance from caregivers...." Occupational Therapy Summary notes between 1/8/11 and 1/14/11 Findicated, "Patient impulsive and frequently gets up from wheelchair to walk behind it with no assistance." Speech Therapy Summary between 1/8/11 through 1/14/11, indicated the resident was able to demonstrate ability to follow safety precautions with moderate ability (51 to 70% of the time) and had mild cognitive impairment. On 1/14/11 at 5:30 p.m., nursing notes indicated the resident was found on the floor in the doorway of her room. The resident complained of pain in her right hip and right wrist. Subsequently, the resident was sent to the hospital and admitted with a fractured right wrist and right hip. On 2/3/11 at 11:30 p.m., the Director of Rehabilitation was interviewed about Resident #B's mobility alarm. The Director of Rehabilitation	F 280		

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F 280	Continued From page 9 indicated Resident #B was getting stronger and her balance was improving but she still needed assistance to transfer and had no safety awareness. The Director indicated she did not recall having any input when the alarm was discontinued and she felt Resident #B should have had a mobility alarm. On 2/3/11 at 1:20 p.m., CNA #11, who worked with Resident #B, was interviewed about the fall. CNA #10 indicated Resident #B would get up without help and she was told not to get up by herself but she continued to do it. The CNA indicated the resident wanted to go home and was confused at times. On 2/3/11 at 3:15 p.m., LPN #12, who was on duty when Resident #B fell, was interviewed. The LPN indicated the resident #B was in bed when she went to pass drinks in the dining room. She received a call from the CNA, went to check and Resident #B was on the floor in the door way of her room. The resident had pain, EMS was called, and the resident was transported to the hospital. LPN #12 indicated she had "caught" Resident #B being up without assistance twice and told her to call for help. On 2/3/11 at 4:00 p.m., CNA #13, who initially found the resident on the floor on 1/14/11, was interviewed. CNA #13 indicated she saw Resident #B in bed before the fall. The CNA indicated a resident was at the nurses station pointing toward Resident #B's room and when she went around the corner, Resident #B was lying on the floor in her doorway. The CNA indicated she had not worked with Resident #B and had no first hand knowledge about Resident #B getting up on her	F 280		

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F 280	Continued From page 10 own. On 2/4/11 at 10:30 a.m., the Rehabilitation Director was interviewed about Resident #B's fall. The Director indicated Resident #B was not safe walking or transferring alone. The Director indicated she talked to the family on 1/14/11, about their safety concerns. She indicated she then told the evening nurse (LPN #12) that the resident was "not safe" transferring herself and "needed watching." On 2/4/11 at 11:00 a.m., the DON (Director of Nursing) indicated the IDT (interdisciplinary team), including a therapist, discussed Resident #B and identified no new safety issues on 12/30/10 but they had not met formally after 12/30/10 and no new interventions were initiated. The DON further indicated staff were inserviced on 1/27/11 and 1/28/11 and fall risk assessments were to be done before the discontinuation of mobility alarms or fall preventative measures. Finally, the DON indicated, after the fall, the IDT met to evaluate the effectiveness of the fall prevention interventions for all residents at risk for falls. The Fall Management Procedure, dated 10/10, provided by the DON, was reviewed on 2/4/11 at 11:30 a.m., and indicated "...3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries..." This federal tag relates to Complaint IN00085379. 3.1-35(d)(2)(B)	F 280		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 11 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident at risk of falls was thoroughly assessed before a device used to alert staff to the resident's rising unassisted was discontinued, and failed to assure the fall risk care plan was updated when the resident began to attempt to get up unassisted. The resident was not supervised, fell and fractured her hip and wrist. This deficient practice affected 1 of 3 residents who were at risk of falls in a sample of 3. (Resident #B) Findings include: On 2/3/11 at 9:00 a.m., during the orientation tour, the ADON (Assistant Director of Nursing) indicated Resident #B had fallen in the facility and had sustained a hip and wrist fracture. The ADON indicated Resident #B was hospitalized after the fall and returned to the facility following a surgical repair of the hip fracture but currently was in the hospital because a screw in the hip had become displaced. The clinical record of Resident #B was reviewed on 2/3/11 at 10:00 a.m., and indicated the resident was admitted to the facility on 12/3/10 for	F 323	It is the policy of this facility to ensure that the resident environment remains as free from accident hazards as possible: that each resident receives adequate supervision and assistance devices to prevent accidents. Resident B was re-evaluated upon readmission to this facility on 1-19-11. A fall risk assessment was completed with a score indicating high risk. The care plan was reviewed and updated on 1-19-11 to include new interventions of low bed with mat at bedside on floor. New orders were also received from the doctor for a chair pressure alarm, a mobility alarm and a raised edge mattress. All were placed in use on 1-19-11 and the care plan was updated to include all interventions. On 1-27-11 and 1-28-11 all residents charts were reviewed for appropriate and timely fall risk assessments. Those residents that triggered as high risk received an additional audit for appropriate interventions and care plans. On 1-27-11 and 1-28-11, nursing staff consisting of RN, LPN and QMA's	2-4-11 5 *

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	155596	A. BUILDING _____ B. WING _____	C 02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND SKILLED NURSING AND REHABILITATION	500 N WILLIAMS ST ANGOLA, IN 46703

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F 323	Continued From page 12 rehabilitation following a hospitalization for an appendectomy with peritonitis. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, and osteoporosis. The resident had been residing in an assisted living facility prior to her appendicitis. The fall risk assessment, dated 12/3/10, indicated the resident was at high risk of falls and had "intermittent confusion." Admission physician orders, dated 12/3/10, indicated, "Mobility alarm on @ (at) all times (check mark) q (every) shift." Therapy notes indicated Occupational Therapy was started on 12/6/10, Physical Therapy on 12/7/10, and Speech Therapy on 12/13/10. Nursing notes, dated 12/8/10, indicated, "D/c (discontinue) mobility alarm res (resident) uses call light appropriately to convey needs...." There was no documentation Resident #B's safety needs were comprehensively assessed or that the Physical or Occupational Therapists were consulted before the mobility alarm was discontinued. During interview on 2/3/11 at 1:30 p.m., LPN #10, who had discontinued the mobility alarm for Resident #B, indicated she felt the resident's confusion had cleared, the resident was using her call light, was continent, and the family wanted her to be more independent. LPN #10 indicated she did not discuss discontinuing the mobility alarm with the therapists. The fall risk care plan, dated 12/10/10, indicated the resident was at risk of falls related to	F 323	were re-educated on completing fall risk assessments and forwarding recommendations to the IDT prior to discontinuing any safety measure or device. They were also re-educated that the care plan must be updated and reflect any changes for any new or discontinued intervention. A Fall committee was formed that reviews any fall for root caused, any change in risk level and to add any new interventions. All residents are reviewed with IDT walking round the next business day after any fall. Director of Nursing and/or Designee will monitor during routine rounds to ensure that continued compliance is obtained. This area will be reviewed 5x week for one month, per 24 hour report sheet, telephone orders and fall reports, then weekly x4, then monthly through random audits and IDT rounds. Results of the audits will be reported monthly to the QA Committee for review. The QA Committee, responsible to the Administrator, will review audits for continued compliance	

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F 323	Continued From page 13 psychotropic medication, diuretic medication, osteoporosis, Parkinson's, poor safety awareness, dementia and weakness. The care plan included the following interventions: provide adequate lighting, monitor side effects of medication, keep call light within reach, encourage use of call light, keep floors free of spills and clutter, monitor unsteady gait and balance. instruct to avoid sudden position changes, labs as ordered, assess toileting needs, provide verbal safety cues, keep personal belongings within reach, keep assistive devices within easy reach: (walker, wheelchair), wear clear and clean eye wear, provide non-skid foot wear, Physical Therapy evaluation and treatment, and Occupational Therapy evaluation and treatment. No additional interventions were implemented until 1/19/11, after the resident returned from the hospital, following the repair of her hip fracture. A Social Services 30 day summary, dated 12/27/10, indicated the resident received a score of 7 on the BIMS (Brief Interview for Mental Status) indicating the resident had severe mental status impairment (0-7 severe impairment). Nursing notes indicated the following: On 1/4/11 at 8:30 p.m., Resident #B was showing increased independence and was walking without help in her room and down the hall. On 1/11/10 at 8:35 p.m., resident was found to be walking in the hall without her wheel chair.	F 323		

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F 323	Continued From page 14 Physical Therapy Summary notes, between 1/11/11 and 1/14/11, indicated the resident required contact guard assist for safe transfer and ambulation due to unsteadiness. The summary indicated the resident was a fall risk and "safety precautions include need for verbal, tactile and visual cues." The note further indicated "Pt (patient) is attempting to walk without assistive devices or assistance from caregivers...." Occupational Therapy Summary notes between 1/8/11 and 1/14/11 indicated, "Patient impulsive and frequently gets up from wheelchair to walk behind it with no assistance." Speech Therapy Summary between 1/8/11 through 1/14/11, indicated the resident was able to demonstrate ability to follow safety precautions with moderate ability (51 to 70% of the time) and had mild cognitive impairment. On 1/14/11 at 5:30 p.m., nursing notes indicated the resident was found on the floor in the doorway of her room. the resident complained of pain in her right hip and right wrist. Subsequently, the resident was sent to the hospital and admitted with a fractured right wrist and right hip. On 2/3/11 at 11:30 p.m., the Director of Rehabilitation was interviewed about Resident #B's mobility alarm. The Director of Rehabilitation indicated Resident #B was getting stronger and her balance was improving but she still needed assistance to transfer and had no safety awareness. The Director indicated she did not recall having any input when the alarm was discontinued and she felt Resident #B should have had a mobility alarm.	F 323		

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F 323	Continued From page 15 On 2/3/11 at 1:20 p.m., CNA #11, who worked with Resident #B, was interviewed about the fall. CNA #10 indicated Resident #B would get up without help and she was told not to get up by herself but she continued to do it. The CNA indicated the resident wanted to go home and was confused at times. On 2/3/11 at 3:15 p.m., LPN #12, who was on duty when Resident #B fell, was interviewed. The LPN indicated the resident #B was in bed when she went to pass drinks in the dining room. She received a call from the CNA, went to check and Resident #B was on the floor in the door way of her room. The resident had pain, EMS was called, and the resident was transported to the hospital. LPN #12 indicated she had "caught" Resident #B being up without assistance twice and told her to call for help. On 2/3/11 at 4:00 p.m., CNA #13, who initially found the resident on the floor on 1/14/11, was interviewed. CNA #13 indicated she saw Resident #B in bed before the fall. The CNA indicated a resident was at the nurses station pointing toward Resident #B's room and when she went around the corner, Resident #B was lying on the floor in her doorway. The CNA indicated she had not worked with Resident #B and had no first hand knowledge about Resident #B getting up on her own. On 2/4/11 at 10:30 a.m., the Rehabilitation Director was interviewed about Resident #B's fall. The Director indicated Resident #B was not safe walking or transferring alone. The Director indicated she talked to the family, on 1/14/11, about their safety concerns. She indicated she then told the evening nurse (LPN #12) that the	F 323		

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F 323	Continued From page 16 resident was "not safe" transferring herself and "needed watching." The Director indicated she did not document the conversations with the family or the nurse. On 2/4/11 at 11:00 a.m., the DON (Director of Nursing) indicated the IDT (Interdisciplinary Team), including a therapist, discussed Resident #B and identified no new safety issues on 12/30/10 but they had not met formally after 12/30/10 and no new interventions were initiated. The DON indicated the resident had no falls before 1/14/11. The DON further indicated staff were inserviced on 1/27/11 and 1/28/11 and fall risk assessments were to be done before the discontinuation of mobility alarms or fall preventative measures. Finally, the DON indicated, after the fall, the IDT met to evaluate the effectiveness of the fall prevention interventions for all residents at risk for falls. The Fall Management Procedure, dated 10/10, provided by the DON, was reviewed on 2/4/11 at 11:30 a.m., and indicated, "...3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries..." This federal tag relates to Complaint IN00085379. 3.1-45(a)(2)	F 323		